STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 18,401
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Department of Prevention, Assistance, Transition, and Health Access (PATH) denying her payment for medical expenses under the Vermont Health Access Program (VHAP) based on her lack of eligibility for the program at the time the services were rendered.

FINDINGS OF FACT

1. The petitioner was a VHAP recipient in the year 2002 when a medical condition affected her use of her arms and hands. In March of 2002, she was seen by medical providers chosen by her from a list of physicians enrolled in the VHAP program. The petitioner says that she was initially misdiagnosed by one physician but that another eventually correctly diagnosed her with possible cervical spine problems. The latter physician requested approval for an MRI in May of 2002 to confirm this diagnosis. The MRI approval was delayed because of lack of supporting information but was eventually approved and the procedure was performed in July of 2002.

Thereafter, the petitioner had cervical spine surgery on August 1, 2002. The petitioner felt that the process from diagnosis to treatment took too long but she did not file any complaints or appeals at that time. VHAP covered the cost of these procedures.

2. The petitioner continued to have problems after surgery including swollen hands and radiating pain in her legs. The petitioner was seen again by her physician in November of 2002 at which time he recommended a second MRI of her lumbar spine and referred her to a specialist for evaluation of her swollen hands which he characterized as carpal tunnel syndrome.

3. On November 25, 2002, the petitioner's physician requested the follow-up MRI for her spine through the VHAP prior approval process which is handled by a subcontracting organization. On December 4, 2002 PATH notified the petitioner that her application for prior approval was incomplete because it did not contain supporting documentation. She was allowed 12 days to submit the documentation. The documentation was submitted to the subcontractor before the deadline and the MRI was approved by PATH on December 17, 2002. The approval decision was mailed to the petitioner with a notation that the service had to be

completed before February 2, 2003. The notice also advised the petitioner that the "authorization is valid only if the patient is eligible on the date of service."

4. At the same time the prior approval request was being processed, the petitioner's general eligibility for the VHAP program came up for review. The petitioner's family's income had increased due to her husband's receipt of a VA pension. This new income had been reported to PATH in September of 2002. The family's new income, including that of her husband and minor son, added up to $3,300 per month. The petitioner was notified on December 3, 2002 that her VHAP benefits would close on December 31, 2002 due to excess income. In spite of the inclusion of her appeal rights on the notice, the petitioner did not appeal that decision in time to continue her VHAP benefits nor did she appeal that decision within ninety days of its issuance. The petitioner says that she did try to file an appeal at that time but there is no record of an appeal and there was certainly no follow-up by the petitioner when she failed to receive a hearing or continuing benefits after several months. The petitioner took no actions that would support her contention and it cannot be found that any appeal was filed within the ninety-day period.

5. At the time the petitioner received this notice, she had hand surgery scheduled for January 6, 2003 and an MRI that had been originally scheduled for December 18 but had been rescheduled by the hospital to January 14, 2003. She called PATH to find out whether these procedures would be covered because they were scheduled after the closing date of VHAP eligibility on December 31, 2002. PATH told the petitioner that the procedures would not be covered if they were performed after December 31, 2002 and urged her to try to get them re-scheduled for December.

6. The petitioner attempted but could not get the surgery or MRI scheduled for December due to the short lead-time and the intervention of the holidays.

7. The petitioner had her hand surgery on January 6, 2002 and her MRI on February 18, 2002, after two further reschedulings by the hospital. She understood that PATH said it would not pay for services on those dates but the petitioner went forward anyway both because she needed the services and because she thought she might be able to prevail on PATH to pay the expense on appeal.

8. The hospital and physician submitted their bills to PATH for the surgery on January 6, 2002 which bills were rejected for payment by PATH based on the petitioner’s lack of

coverage. The MRI was never billed to PATH but rather went directly to the petitioner in the amount of $973.00.

9. The petitioner appealed PATH's denial of payment of all her bills on March 27, 2003. PATH informed the petitioner that the physician and hospital charge for the January 6, 2002 surgery was billed to the petitioner in violation of VHAP provider rules which prevent balance billing a participant after denial by PATH. PATH notified those providers that they could not bill the petitioner for amounts PATH they had rejected. However, the MRI charge of $973 was never billed to PATH for payment but rather directly to the petitioner, an action that does not implicate VHAP rules. PATH asserted that it was not responsible for paying any of these bills as the petitioner was no longer eligible for VHAP on the dates of her procedures and had been so advised.

10. The petitioner disagrees with PATH saying that it should be responsible for payment of these bills because its procedures prevented her from receiving medical care in a timely manner during the period of time she was eligible for benefits. She points to initial misdiagnoses by VHAP approved providers, delays in receiving approvals for medical procedures, and the rescheduling of procedures by the hospital. She also cites the failure of PATH to give her

adequate warning that her benefits would terminate to enable her to schedule needed medical procedures before the termination.

ORDER

The Department's decision is upheld.

REASONS

The petitioner first claims that PATH acted wrongly in delaying approval for medical procedures. Under its regulations, PATH may require prior authorization of any procedure to ensure that it is “medically needed” and is the “least expensive, appropriate health service” in order to “manage the expenditure of program funds.” Medicaid Manual 106. The regulations also require that the physician’s request for prior authorization must be supported at a minimum by a completed claim form and by other information which PATH feels is necessary to make the above judgements. M106. If additional statements are deemed necessary, PATH must notify the provider “promptly” of the need for that information and make a decision on the authorization within thirty days of receiving the original request. M106.5.

In this case, PATH notified the petitioner that additional information was needed nine days after the original

request was filed. After receiving the additional information, it issued the decision to approve the procedure twenty-two days after the initial request was made. These facts do not lead to the conclusion that PATH violated its regulation on prior authorizations with regard to the November 25, 2002 request.[1]

The petitioner also brought up the issue of her family's income and the notice period she received before termination of her benefits. These notices were sent and received in early December 2002, more than one hundred and ten days before the petitioner appealed on March 27, 2003. As such, the petitioner's appeal is outside of the ninety-day appeal time limit and may not be heard by the Board for lack of jurisdiction. See Fair Hearing Rule No. 1. Even if it could be found that the petitioner had timely appealed, the Board would have been constrained to conclude that the petitioner with $3,300 in gross family income could not meet the $2,353 income maximum for a three person family in the VHAP program

[1] Although the petitioner raised concerns about her prior request for an MRI in May of 2002, the petitioner submitted no specific information about those requests and the Board has no jurisdiction to review them since the time period to appeal those decisions has long passed. See Fair Hearing Rule No. 1. The complaint about the latest review is also technically out of date although the petitioner is given the benefit of the doubt that she may not have received the notice dated the 17th of December until close to December 27th, a date within 90 days of the date of her appeal.

even if she were given every deduction available under the regulations. VHAP 4001.84, P-2420A. The Board would also be constrained to conclude that the petitioner received adequate advance notice of the closing of her VHAP benefits as the regulations require the mailing of the notice at least eleven days before termination and the petitioner's notice was mailed twenty-eight days before termination. VHAP 4002.32. Since the petitioner was not eligible for benefits and was given adequate notice of that fact, PATH has no obligation to pay medical bills that she incurred after her termination. VHAP 4000, 4001, 4001.8 and 4001.84.

It cannot be concluded that PATH violated any of its regulations in its dealings with the petitioner. The only argument remaining to the petitioner is one in the nature of estoppel, that is, that PATH failed in its duty to her and thereby caused her harm which she was in no position to avoid and which should, as a consequence, bar PATH from enforcing its rules against her. The four elements of estoppel adopted by the Vermont Supreme Court are: "(1) the party to be estopped must know the facts; (2) the party to be estopped must intend that its conduct shall be acted upon or the acts must be such that the party asserting the estoppel has a right to believe it is so intended; (3) the party asserting estoppel

must be ignorant of the true facts; and (4) the party asserting estoppel must detrimentally rely on the conduct of the party to be estopped." Burlington Fire Fighters' Ass'n. v. City of Burlington, 149 Vt. 293, 299, 543 A2d 686, 690-91 (1988) as cited in Stevens v. Department of Social Welfare, 159 Vt. 408, 421 (1992).

The petitioner claims that PATH failed in its duty to her both by delaying her health care and by failing to advise her in a timely manner that her benefits were about to end so that she could schedule her health care before the termination. There was no evidence presented, however, that PATH eligibility workers had any reason to know before she contacted them in mid-December that the petitioner was engaged in a course of health care that she felt was being unduly delayed or that she needed to complete further medical procedures before her eligibility ceased. It cannot be found, therefore, that PATH knew or should have known any of the facts relevant to this matter or that PATH gave the petitioner any misinformation about her situation.

The petitioner, on the other hand, knew that she was involved in a protracted effort to remedy her heath concerns and knew that the family's income had increased. Yet, she did not complain to PATH in all the ten months of her ordeal about

her treatment nor did she ask anyone whether her husband's increased income might lead to her ineligibility at her six-month review. She knew as of early December that she would no longer be eligible for benefits after the end of the year. When she did finally contact PATH in mid-December, she received accurate information about PATH's obligation to pay her bills after December 31, and was told to schedule all of her outstanding medical appointments before that date. It cannot be found that the petitioner was ignorant of the pertinent facts.

When the petitioner went ahead with the procedures after December 31, the petitioner was not relying on information from PATH that those procedures would be covered but rather on her own need for the procedures and her unfounded hope that VHAP would eventually cover her. It cannot be found, therefore, that the petitioner detrimentally relied on information given to her by PATH when she incurred medical bills after December 31. It must be concluded that the petitioner has failed to show any, let alone all, of the necessary elements which might entitle her to receive payment of her medical bills by PATH on fairness grounds.

There is no relief which the Board can give to the petitioner in this matter. PATH has intervened to keep its

participating health providers from charging her after VHAP denied the claim pursuant to agreements it has with those providers. The petitioner should be aware, however, that the physicians and hospitals that she has chosen are not PATH's agents and their errors in diagnosing her or delays in seeking authorizations for treatment or providing information on her behalf are not the errors of PATH. PATH's decision that it could not pay for health services provided to the petitioner after her eligibility ended is correct and must be upheld by the Board. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 17.

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